

NOV 18 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Jackson
 Township 722
 City Camden (No. 722 Gen. Dist.)

Registration District No. 309Primary Registration District No. 1002

File No. 36522
 Registered No. 97
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 6208 E. 12th St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>1</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>2-27-1902</u>		
7. AGE	YEARS	MONTHS
<u>35</u>	<u>1</u>	<u>3</u>
		8. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year)
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 72213. NAME John, William W14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 72215. MAIDEN NAME Ware Gertrude16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 72217. INFORMANT (ADDRESS) Margaret John18. BURIAL, CREMATION, OR REMOVAL
PLACE Int. Church DATE Oct 2 193719. UNDERTAKER (ADDRESS) C. H. Bleckman20. FILED 19-1 1937 M. M. Crowe, asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-30 193722. I HEREBY CERTIFY, That I attended deceased from 9-30, 1937 to 9-30, 1937I last saw him alive on 9-30, 1937 Death is saidto have occurred on the date stated above, at 9:15 AM

The principal cause of death and related causes of importance were as follows:

Pneumonia Date of onsetOther contributory causes of importance: 108Name of operation Pneumococcus Date of _____What test confirmed diagnosis Autopsy Was there an autopsy? yes23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

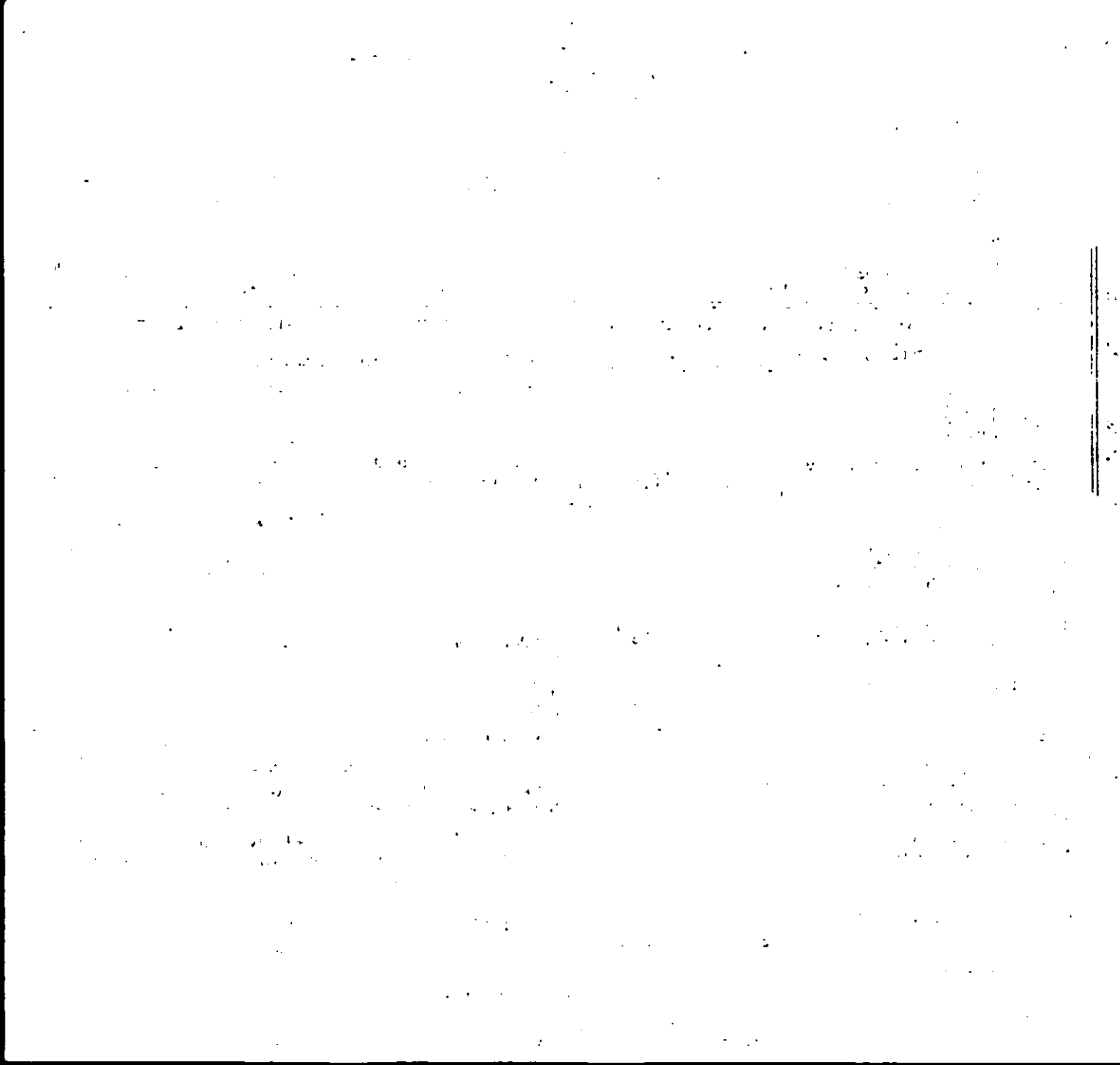
Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) P. H. De Maria M. D.(Address) Superior City Hospital



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

365-22

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township _____ Primary Registration District No. 1002
(c) City Kansas City (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John, William Dana

(a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 35 MONTHS 7 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10/1 1937 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19 _____

22. I HEREBY CERTIFY, That I attended deceased from _____, 19 _____, to _____, 19 _____

I last saw h. _____ alive on _____, 19 _____. Death is said to have occurred on the date stated above, at _____. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

5-36522